# Patient Health Questionnaire

**Name:**

**Age:**

**Marital Status:**

**Date:**

**Height:**

**Weight:**

**General Health is:**

**Have you had a cold or flu in the past month:**

**Are symptoms still present:**

**Have you ever had or been told that you had any of the following conditions:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES/NO</th>
<th>Condition</th>
<th>YES/NO</th>
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</thead>
<tbody>
<tr>
<td>Heart Trouble/Congestive Heart Failure</td>
<td></td>
<td>Glaucoma or Eye Disorder</td>
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<tr>
<td>Heart Attack/ Chest Pain</td>
<td></td>
<td>Visual Disturbances</td>
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<tr>
<td>Endocarditis</td>
<td></td>
<td>Other Eye Problems</td>
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<tr>
<td>Palpitations or Irregular Pulse</td>
<td></td>
<td>Hepatitis A</td>
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<tr>
<td>Extra Heart Beats</td>
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<td>Hepatitis B or C</td>
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<tr>
<td>Mitral Valve Prolapse</td>
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<td>Jaundice</td>
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<tr>
<td>Stroke or TIA (Transient Ischemic Attack)</td>
<td></td>
<td>Gallstones or Gallbladder Trouble</td>
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<tr>
<td>Blood Disease</td>
<td></td>
<td>Cirrhosis of the Liver</td>
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<tr>
<td>High Blood Pressure</td>
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<td>Alcoholism</td>
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<tr>
<td>Abnormal Electrocardiogram (EKG)</td>
<td></td>
<td>Esophageal Varices</td>
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<tr>
<td>Rheumatic Fever</td>
<td></td>
<td>Frequent Indigestion</td>
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<tr>
<td>Shortness of Breath</td>
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<td>Ulcers</td>
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<tr>
<td>Asthma</td>
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<td>Gastritis</td>
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<tr>
<td>Bronchitis</td>
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<td>Colitis/Crohn's Disease</td>
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<td>Tuberculosis</td>
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<td>Constipation</td>
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<tr>
<td>Pneumonia</td>
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<td>Vomiting Blood</td>
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<tr>
<td>Smoker's Cough</td>
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<td>Tarry or Bloody Bowel Movements</td>
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<tr>
<td>Emphysema</td>
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<td>Hemmorhoids</td>
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<tr>
<td>Coughing or Spitting Blood</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Hay Fever or Other Allergies</td>
<td></td>
<td>Diabetes</td>
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<tr>
<td>Frequent Respiratory Infections</td>
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<td>Skin Disorders/Rashes</td>
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<tr>
<td>Nervous Disorder</td>
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<td>Arthritis</td>
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<tr>
<td>Insomnia</td>
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<td>Fracture of Neck or Spine</td>
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<tr>
<td>Drug Addiction/Habit</td>
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<td>Bleeding Tendency or Disorder</td>
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<tr>
<td>Psychiatric Hospitalization or Care</td>
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<td>Blood Infection</td>
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<tr>
<td>AIDS or HIV Infection</td>
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<td>Airway Obstruction (Nasal)</td>
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<tr>
<td>Herpes/Syphilis/or Gonorrhea</td>
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<td>Breast Cysts, Tumors, Abscesses</td>
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<tr>
<td>Cancer</td>
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<td>Nipple Discharge</td>
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<tr>
<td>Kidney/Bladder Problems</td>
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<td>Blood Transfusion</td>
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<tr>
<td>Seizures/ Seizure Disorder</td>
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PATIENT HEALTH QUESTIONNAIRE

1. Do you have allergic reactions to any medication? YES NO If so, to which meds?

2. Do you react abnormally to any medication? YES NO If so, to which meds?

3. Do you have an allergic reaction to contrast material? YES NO

4. Do you have any family history of cancer, heart trouble, stroke, diabetes, or kidney problems? YES NO
   If so, which family member(s)?

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? YES NO If so how much?

6. Do you smoke? YES NO If so how much?

7. Do you have a history of excessive bruising or bleeding following surgery or minor trauma (including tooth extractions or mouth trauma)? YES NO

8. Have you, or your blood relatives required blood transfusions following previous surgery or trauma? YES NO
   If so, please specify:

9. Are you pregnant? YES NO When was your last menstrual period? ___ / ___ / ___
   Was it normal? YES NO


11. Have you ever been on Cortisone or steroid treatment? YES NO If so, when?

12. Please list all present medications and dosages, including Birth Control Pills, Hormones, Vitamins, and Over-the-Counter medications:

13. Do you take Diuretics? YES NO If so, what?

14. When was your last Physical Exam? ___ / ___ / ___ By Whom: Dr.

15. When was your last Eye Exam? ___ / ___ / ___ By Whom: Dr.

16. When was your last Electrocardiogram (EKG) and where?

17. When was your last Chest X-ray and where?

18. Please list ALL prior hospitalizations and surgical operation, including date and reason:

HOSPITALIZATIONS:

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Reasons</th>
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Surgical Operations:

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</table>

Drug History: Taken In Last 6 Months:

- STEROIDS (CORTISONE, ACTH, ETC)
- TRANQUILIZERS
- ANTIBIOTICS
- NARCOTICS
- DIABETIC MEDICATION
- BLOOD PRESSURE MEDICATION
- THYROID MEDICATION
- HEART MEDICATION
- ARTHRITIS MEDICATION
- OTHER:

Patient's Signature: ___________________________ Date: ____ / ____ / ____
Release Statement

Consent to Use of Images/Videos on an Internet Website in a Medical Case Study or as “Before and After” Example of a Medical Treatment and/or Procedure

I, __________________________ whose signature appears below, do hereby consent to the use of my images in photographs, videos, illustrations, or other likelihoods, for the purposes of publication and display on the internet website(s), social media sites (i.e. Facebook, Snapchat, Instagram, YouTube) and T.V. of:

Steven Wallach, M.D.
1049 5th Avenue, Suite 2D
New York, NY 10028

____________________________  ______________________
Signature                  Date

____________________________
Address

____________________________
City, State, Zip

____________________________
Signature of Parent or Court-Appointed Guardian  Date

Contact us: (212) 861-6400  or email: info@stevenwallachmd.com
Cosmetic Interest Questionnaire

Please check any which interest you.

☐ Botox  ☐ Fillers  ☐ Mole/ Birthmark Removal  ☐ Skin Care
☐ Facelift  ☐ Rhinoplasty  ☐ Blepharoplasty  ☐ Breast Augmentation
☐ Breast Lift  ☐ Breast Reduction  ☐ Breast Implant Revision  ☐ Arm Lift  ☐ Thigh
☐ Lift  ☐ Breast Reconstruction  ☐ Abdominoplasty  ☐ Liposuction  ☐ Body
☐ Sculpting  ☐ Body Lift  ☐ Brazilian Butt Lift  ☐ Butt Dream Lift
☐ Buttock Implants

Other: ________________________________

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When viewing my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than  | True Age | Older Than
1 | 2 | 3 | 4 | 5

I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned  | Somewhat Concerned | Very Concerned
1 | 2 | 3 | 4 | 5

Contact us: (212) 861-6400  or email: info@stevenwallachmd.com
PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs by Dr. Steven Wallach or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Steven Wallach. I further consent to the release by Dr. Steven Wallach to the American Society of Plastic Surgeons ("ASPS") or the American Society of Aesthetic Plastic Surgery ("ASAPS") of such photographs.

I understand that such photographs may be published by ASPS, or ASAPS in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Steven Wallach.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS, or ASAPS.

I release and discharge Dr. Steven Wallach, ASPS, ASAPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient ___________________________________________ Date ___________________________

WITNESS/PHYSICIAN __________________________________________________________

I have read the above Authorization and Release. I am the parent, guardian or conservator of ________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian ___________________________________________ Date __________________________

Contact us: (212) 861.6400 or email: info@stevenwallach.com
Dear Patient,

This is a summary of the way medical information about you may be used and disclosed, and how you can get access to this information. Dr. Wallach and his entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by the health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal and state law.

This compliance with the “Notice of Privacy Practices for Protected Health Information” as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

The attached Notice is effective as of April 14, 2003.
# Thrombosis Risk Factor Assessment

**Choose all that apply**

### Each Risk Factor Represents 1 Point
- □ Age 41-60 years
- □ Minor surgery planned
- □ History of prior major surgery (< 1 month)
- □ Varicose veins
- □ History of inflammatory bowel disease
- □ Swollen legs (current)
- □ Obesity (BMI > 25)
- □ Acute myocardial infarction
- □ Congestive heart failure (< 1 month)
- □ Septis (< 1 month)
- □ Serious lung disease including pneumonia (< 1 month)
- □ Abnormal pulmonary function (COPD)
- □ Medical patient currently at bed rest
- □ Other risk factors

### Each Risk Factor Represents 2 Points
- □ Age 60-74 years
- □ Arthroscopic surgery
- □ Malignancy (present or previous)
- □ Major surgery (> 45 minutes)
- □ Laparoscopic surgery (> 45 minutes)
- □ Patient confined to bed (> 72 hours)
- □ Immobilizing plaster cast (< 1 month)
- □ Central venous access

### Each Risk Factor Represents 3 Points
- □ Age over 75 years
- □ History of DVT/PE
- □ Family history of thrombosis
- □ Positive Factor V Leiden
- □ Positive Prothrombin 20210A
- □ Elevated serum homocysteine
- □ Positive lupus anticoagulant
- □ Elevated antiphospholipid antibodies
- □ Heparin-induced thrombocytopenia (HIT)
- □ Other congenital or acquired thrombophilia

### For Women Only (Each Represents 1 Point)
- □ Oral contraceptives or hormone replacement therapy
- □ Pregnancy or postpartum (< 1 month)
- □ History of unexplained stillborn infant, recurrent spontaneous abortion ≥3, premature birth with toxemia or growth-restricted infant

### Total Risk Factor Score

2005 Caprini Risk Assessment Model
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Joseph A. Caprini, MD

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**Patients' Name:**

**Age:**

**Sex:**

**Weight:**